

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022873

STATE FILE NUMBER

Registration District No. 325 Primary Registration District No. 4480 Registrar's No. _____

DO NOT WRITE
ON THIS STUB

AMENDED

FILED JUN 14 1963

1. PLACE OF DEATH a. COUNTY SCHUYLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY SCHUYLER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN GREENTOP		c. CITY OR TOWN GLENWOOD,	
Length of stay in lb 6 mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION GREENTOP NURSING HOME		d. STREET ADDRESS NONE (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First JULIA Middle ANNA Last ROBERTS			4. DATE OF DEATH Month June Day 5 Year 1963		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1870	9. AGE (last birthday) 92	IF UNDER 1 YEAR Months 6 Days 3 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (City and state or country) SCHUYLER	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME FREDERICK SAEGER			
13b. MOTHER'S MAIDEN NAME JULIA ANNA LUNTZMANN		14. NAME OF HUSBAND OR WIFE GEORGE ROBERTS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 		17. INFORMANT HERMAN ROBERTS, GLENWOOD, MISSOURI	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Failure DUE TO (b) Hypertensive Pre-eclampsia DUE TO (c) Progressive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 weeks 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteritis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Glenwood, Missouri		
21. I attended the deceased from 8/30/62 to 6/15/63 and last saw her alive on 6/4/63 Death occurred at 3:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE Edward M. Roberts, M.D.		23. ADDRESS Green City, Mo.	
24. DATE SIGNED 6/7/63		25. DATE RECD. BY LOCAL REG. 6-8-1963	
26. REGISTRAR'S SIGNATURE Clarence Shepherd		27. ADDRESS Glenwood, Missouri	

24. FUNERAL DIRECTOR **Norman Funeral Home, Lancaster, Mo.** 25. DATE RECD. BY LOCAL REG. **6-8-1963** 26. REGISTRAR'S SIGNATURE **Clarence Shepherd**

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59
1 0980
2 0980
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9 434.1
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12 86-2
13 1-0

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

James E. Foster

Licensed Embalmer No. *4742*

P. O. Address *Hicksville, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Permit obtained 6-8-63